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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDEN'INFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S	
			B. WING		-	
MANE ALL	PROVIDER OR SUPPLIER	445228	S. WING		07/2	7/2012
	RE CENTER OF GRE	ENEVILLE	- 1	TREET ADDRESS, CITY, STATE, ZIF 725 CRUM STREET GREENEVILLE, TN 37743	CODE	
(X4) (D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 000			
\$S=D	investigation #2874 on July 23-27, 2012 Greeneville. No de complaint investiga under 42 CFR PAR Long Term Care Fa 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must infand in writing in a la understands of his oregulations governing responsibilities during facility must also pronotice (if any) of the §1919(e)(6) of the Amade prior to or upon amendments to writing. The facility must information of admission to the infanction of admission to the infanction of the second complex control of the second control of the seco	cation survey and complaint 2 and #30028 were completed 2, at Life Care Center of ficiencies were cited related to tion #28742 and #30028 T 482.13, Requirements for ciclities. 483.10(b)(1) NOTICE OF SERVICES, CHARGES corm the resident both orally anguage that the resident or her rights and all rules and ang resident conduct and ang the stay in the facility. The both the resident with the State developed under act. Such notification must be on admission and during the ceipt of such information, and it, must be acknowledged in form each resident who is benefits, in writing, at the time hursing facility or, when the ligible for Medicaid of the	[—] F 156	What corrective action (s) vaccomplished for those resibeen affected by the deficie a) Social Services, Admis Office personnel were procedure of issuing Landices prior to dischathe Executive Director. How you will identify other the potential to be affected by practice and what corrective taken: a) All residents current Medicare services have the potential to be put if systematic changes you will that the deficient practice do a) Social Services, Ac Business Office perserviced on approper and expectations of and Appeal Notice discharge by the Experiment of the services on the potential of the services of the perserviced on the potential of the services of the perserviced on the potential of the perserviced on the potential of the perserviced on the potential of the perserviced on the perserviced on the potential of the perserviced on the potential of the perserviced on the	dents found to have nt practice: ssions & Business in-serviced on iability and Appeal rge on 8/2/12 by residents having to the same defiant action will be ntly receiving upon discharge to be affected. Into place or what make to ensure the sound were in- riate procedure issuing Liability is prior to	9/10/1
	items and services t facility services unde	hat are included in nursing er the State plan and for pay not be charged; those		on 8/2/12. b) Liability and Appearissued prior to disci	al Notices will be harge.	
[other items and servand for which the re- the amount of charginform each resident	vices that the facility offers sident may be charged, and es for those services; and twhen changes are made to es specified in paragraphs (5)		c) Social Services Dir Business Office Ma will conduct financ weekly for 4 weeks months to monitor Liability and Appea completion prior to	ector and/or anager Assistant ia) record audits and monthly for 2 compliance of al Notice	

Any deficiency statement ending with an esterist (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE S	URVEY
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	PROVIDER OR SUPPLIER RE CENTER OF GREE	ENEVILLE		7	REET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ICULD BE	(X5) COMPLETION DATE
	at the time of admis the resident's stay, of facility and of charge including any charge under Medicare or but the facility must furn legal rights which inched a description of the personal funds, und section; A description of the personal funds, und section; A description of the for establishing eligible the right to request a 1924(c) which determine the cannot be considere toward the cost of the medical care in his of down to Medicaid eligible. A posting of names, numbers of all pertingroups such as the Sagency, the State lice ombudsman program advocacy network, a unit; and a statement complaint with the Stagency concerning remisappropriation of remisagency programs.	sion, and periodically during of services available in the est for those services, as for services not covered by the facility's per diem rate, which a written description of cludes: manner of protecting er paragraph (c) of this requirements and procedures could be a sessible of a couple's est at the time of and attributes to the community share of resources which die available for payment e institutionalized spouse's reprocess of spending gibility levels. addresses, and telephone ent State client advocacy state survey and certification ensure office, the State on, the protection and the Medicaid fraud control of that the resident may file a late survey and certification esident abuse, neglect, and esident property in the poliance with the advance	F1	56	How the corrective action(s) will monitored to ensure the deficient not recur: a) Beginning 8/2/12 Liability Appeal Notices will be it discharge. Social Service and/or Business Office Massistant will begin condition financial record audits we weeks and monthly for 2 monitor completion of L. Appeal Notices upon discharge will report results from the facility's Executive D. The Performance Improve Committee will review the and; if deemed necessary committee, additional educe be provided. The process evaluated/revised and/or reviewed for 3 months or compliance is achieved. d) Performance Improvemer Committee members are the Executive Director, the Moirector, the Director of Nurse MDS Coordinator, the PP Rehab Service Manager, the Pharmacist, Maintenance Director, the Office Manager, the Hous Supervisor, the Staff Deve Coordinator and the Wour Nurse.	ty and sued prior to es Director fanager lucting eekly for 4 months to ability and charge. ctor and/or Assistant e audits to irector. ement e results by the location may may be the audits until 100% at the edical fursing, the ing, the S Nurse, the he Social try the Business ekeeping lopment	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 156	specified in subpart related to maintaini procedures regardi requirements include provide written inforcements include surgical treatment option, formulate are includes a written opticies to impleme applicable State law. The facility must informate, specialty, an physician responsibility must prowritten information, applicants for admissinformation about he Medicare and Medicare and Medicare such benefits.	imply with the requirements of of part 489 of this chapter on written policies and one advance directives. These deprovisions to inform and relation to all adult residents of to accept or refuse medical of and, at the individual's of advance directive. This escription of the facility's of advance directives and or and provide to residents and assion or all and written ow to apply for and use caid benefits, and how to previous payments covered by	F	156			
	by: Based on interview financial record the Liability and Appeal residents (#61 & #1)	IT is not met as evidenced and review of the resident's facility failed to provide notices to two dicharged 60) of thirty one residents of the quality indicator survey.					
		d: lial record review with the itor in the facility conference					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER:	(2) MULTII . BUILDIN	PLE CONSTRUCTION	·	(X3) DATE SURVEY COMPLETED		
	44522	28 S	. WING _			07/2	7/2012
NAME OF PROVIDER OR SUI LIFE CARE CENTER O			7	EET ADDRESS, CITY 25 CRUM STREET REENEVILLE, TI		•	
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENC FICIENCY MUST BE PRECEDED I RY OR LSC IDENTIFYING INFOR	BY FULL P	IO REFIX TAG	(ÉACH CORF	R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
the facility fawith a Liability 1483.13(a) RI PHYSICAL F The resident physical rest discipline or treat the resi This REQUII by: Based on mand interview resident (#20 of thirty-one Quality Indic.) The findings Resident #20 25, 2012, with Disease, Del Medical recondated the impaired and ADLs (Activity review reveal physical rest Medical recondated May 20 been assess	v 26, 2012, at 9:03 a.m., cilled to provide resident #6 by and Appeal notice. GHT TO BE FREE FROM RESTRAINTS has the right to be free fraints imposed for purpose convenience, and not requent's medical symptoms. REMENT is not met as event and the facility failed to ensure the facility failed to the facility failed to the facility failed to the facility failed to the facility dependent on statics of Daily Living). Contiled the resident did not recident the facility dependent on statics of Daily Living). Contiled the resident did not recident was severely contiled the resident did not recident did not recident did not recident did not recident was severely contiled the resident did not recident did not recident did not recident was severely contiled the resident did not recident did n	om any ses of uired to videnced ervation ure one I restraints ge 2 of the cility on May cheimer's found. In Minimum ine 1, 2012, gnitively ff for all inued MDS equire	F 156	What corrective: accomplished for been affected by a) All licent serviced releasing 8/6/12 to Develop by Resident reassess restraint resident better many self released and care the potential to be practice and what taken: a) All resident position to be affected by All resident proper other reasfected what measures systematic chant that the deficient all All licent in-services and all licent in-services and coordinated the self-released by the services and that the deficient coordinated the services are services and the services are services and the services are services and the services and the services are services and the services and the services are services and the services and the services are services are services and the services are services and the services are services are services and the services are services are services and the services are services and the services are services are services and the services are services are services ar	those residents for the deficient practi- nsed personnel were and positional decorrect assessing and positional decorrect assessing and positional decorrect Coordinator. It #203 re-evaluated in gourrent device to committee determing current device to a constitute a committee determing a constitute determing device discost plan updated on 8 centify other resident and devices have the fected. The corrective action dents with self relevant devices were as intervention on 8/7, esidents were found.	ce: e in- nent of self vices on the Staff I and after the ined seds was on 8/3/12. ts baving ame defiant will be asing and e potential asing and sessed for /12. No I to be ce or what to ensure recur: nnel were evelopment sessment of	9/10/12

CTATERIES	IT OF DEFICIENCIES				······································	OIMP NO	<u>. 09</u> 38-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	AULTIF ILDING	PLE CONSTRUCTION	(X3) DATE S COMPLI	
		445228	B. Wil	NG		07/2	7/2012
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(X4) ID PREFIX TAG	{EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD 8E	(X5) COMPLETION DATE
F 272 \$S=D	unassisted) on May review revealed on was reduced to a set type restraint. Observation of residence (Aspen) hall nursing confused and mumb release alarming set waist. The resident viseat belt when require observations. Interview with the Clion July 25, 2012, at nursing station, confunable to follow the seat belt. Continued device could not be was a restraint. 483.20(b)(1) COMPI ASSESSMENTS The facility must con a comprehensive, ac reproducible assessing functional capacity. A facility must make assessment of a resident assessment by the State. The as least the following:	to prevent rising from a chair 27, 2012. Continued record May 28, 2012, the lap buddy elf release alarming seat belt lent #203, on July 24, 2012, at July 25, and had a self at belt secured around the was unable to release the lested, at the time of both linical Manager for the A hall lined the resident was command to self release the linterview confirmed the released by the resident and REHENSIVE	F2		b) Restraint Committee will correct assessment of so and positional devices from and monthly thereafter. c) Restraint Committee me Executive Director, the Nursing, the Rehab Services Director and its Services Director. How the corrective action(s) will be ensure the deficient practice will correct assessment of se and positional devices for and monthly thereafter. b) Restraint Committee me Executive Director, the Nursing, the Rehab Services Director. c) The Performance Improvices Director. c) The Performance Improvices Director. c) The Performance Improvices Director. determined if deemed necessary committee, additional educational education in the provided. The process evaluated/revised and/or reviewed for 3 months of compliance is achieved.	elf releasing for 4 weeks embers are the Director of vice Manager, f Nursing, the the Social be monitored ill not recur; ll monitor lf releasing or 4 weeks embers are the Director of vice Manager, f Nursing, the the Social vement the results y by the lucation may as may be r the audits	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	ULTIPLE CONSTRUC	NOIT	COMPLE (X3) DATE SL	
	•	445228	B. WI	G		07/23	7/2012
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	Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of site additional assessareas triggered by Data Set (MDS); and Documentation of purpose the site of performantal and interview, the fassess one resider failed to perform a assessment for one	patterns; peing; g and structural problems; and health conditions; hal status; and procedures; l; summary information regarding ssment performed on the care the completion of the Minimum and participation in assessment. NT is not met as evidenced record review, observation facility failed to accurately action of the restraint (#203), and quarterly bowel and bladder the resident (#93), of thirty-one in Stage 2 of the Quality	F27	Com Exec Direct Assis MDS Reha Servi Mann Mair Offic Supe Coor Nurs What correct accomplishe been affecte a) MI 8/2 corr ass Nu b) Res ass 20 bla by c) Re res and the res bet	ormance Improvement mittee members are the utive Director, the Medictor, the Director of Nursing Coordinator, the PPS I is Service Manager, the Director, the Dictary ager, the Pharmacist, the tenance Director, the Bite Manager, the Housek revisor, the Staff Develor dinator and the Wound e. tive action (s) will be a for those residents for doy the deficient praction of the MDS an essments by the Directorsing. Sident #93 bowel & black casment not completed 12. Resident #93 Bow dder assessment completed 12. Resident #203 not assesse thaint. Resident #203 relation of the MDS coordinator. Sident #203 not assesse thaint. Resident #203 relation of the MDS coordinator. Sident #203 positional not the MDS coordinator.	ical rsing, the rsing, the g, the Nurse, the Social / e susiness reping rpment Care und to have ice: rviced ad d quarterly or of dder in Junc rel & reted 8/2/12 d for e-evaluated ant device termined reds was 8/3/12 ontinued	9/10/12
	•		İ			·	<u>i</u>

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STATEMEN' AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA !DENTIFICATION NUMBER:	(X2) M			TRUCTION	(X3) DATE S COMPLE	
		445228	8. WII	√G			07/2	7/2012
NAME OF F	ROVIDER OR SUPPLIER					ESS, CITY, STATE, ZIP CODE	Ę	
LIFE CA	RE CENTER OF GREI	ENEVILLE		ı	25 CRUM S REENEVI	STREET FILLE, TN 37743		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		<u> </u>		PROVIDER'S PLAN OF CORR	ECTION	1
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EA	ACH GORRECTIVE ACTION S SS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 272	Continued From an	0				u will identify other resid		
1 212	Continued From pa		F 2	272		ntial to be affected by the		i
		admitted to the facility on May		-		and what corrective action	<u>on will be</u>	
		noses including Alzheimer's		1	<u>taken:</u>		_	
	Disease, Dementia	and Right Heel Wound.						,
	Allestical annual const					potential to be affected.		i
		ew of the admission Minimum			.,	•		
•		sessment dated June 1, resident was severely		!		assessments completed		'
		and totally dependent on		ļ		of concern found 8/2/1	.2,	
		ctivities of Daily Living),		i	***	911 1	.4	
		iew revealed the resident did			What me	easures will be put into t	place or what	
	not require physical					tic changes you will mak		
!	nocrogano priyotoat	TOSTIBILIO,		-		<u>deficient practice does no</u> All MDS personnel wer		ļ
	Medical record review	ew of the resident's care plan				on 8/2/12 of proper codi		j l
		, revealed the resident was				completion of the MDS		
		planned for a lap buddy (a		}		assessments by the Dire		
		over the lap and notched to fit				Nursing.	777	
	the arms of a wheel	chair to prevent rising from a					ļ	
		Continued medical record		!	How the	corrective action(s) will	be monitored	•
•		May 28, 2012, the lap buddy		1		e the deficient practice w		·
•		elf release alarming seat belt		İ		Director of Nursing and		
		cal record review revealed the				Director of Nursing will	l do 100%	
		olan had not been updated to				weekly audits on all MI)S	
	reflect the new restr	aining device.		į		assessments and quarter		
i	Ohnanialia, of main	1-14003 July 24 2010 -4		i		assessments for the wee	k for	
		lent #203, on July 24, 2012, at uly 25, 2012, at uly 25, 2012, at 9:55 a.m.,		-		completion of required a		
	toyeoled the recider	ony 20, 2012, at 9:00 a.m.,				will be completed week		
		nt in a geri-chair near the A		ł		and monthly for 2 mont		
j		bling to self and had a self				compliance of MDS ass	essments and	·
		at belt secured around the				quarterly assessments.		
		was unable to self release				Results will be turned in		
İ		equested at the time of both		ļ		Executive Director and/		
	observations.	- description of an interest of		1		Nursing. The Executive		İ İ
!						/or Director of Nursing		
:	Interview with the C	linical Manager for the A hall				findings monthly to the		
: 1	on July 25, 2012, at	10:05 a.m., in the A hall		ļ		Improvement Committee	je.	
	nursing station conf	irmed the resident was unable		ĺ				j
j	to follow the comma	and to self release the seat				•		ļ
				- 1			J	1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		445228	B. WING		07/27/2012	
_	PROVIDER OR SUPPLIER RE CENTER OF GRE	ENEVILLE		REET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	was a restraint and had not been updated assessments and it. Resident #93 was a September 5, 2011 Altered Mental Statementia, and Hyp. Medical record review (MDS) assessment the resident was serequired assistance activities of daily live of bladder, and occumed and Bladthe resident had be 2011, December 5 Interview with LPN a.m., in the MDS on not completed a quassessment since 483.35(i) FOOD PISTORE/PREPARE. The facility must-(1) Procure food from sidered satisfact authorities; and	erview confirmed the device the MDS and the care plan ted to include restraint interventions. admitted to the facility , with diagnoses including itus, Atrial Fibrillation, iertension. ew of the Minimum Data Set t dated May 13, 2012, revealed everely cognitively impaired, of one to two staff with ing, was frequently incontinent easionally incontinent of bowel ew of the facility Assessment der Training record revealed sen assessed September 5, 2011, and March 5, 2012. #1, on July 26, 2012, at 11:00 ffice, confirmed the facility had earterly bowel and bladder March 2012. ROCURE, ESERVE - SANITARY om sources approved or extory by Federal, State or local distribute and serve food	F 27	and; if deemed necessary committee, additional ed be provided. The proces evaluated/ revised and/or reviewed for 3 months or compliance is achieved. d) Performance Improveme Committee members are Executive Director, the Noirector, the Director of Assistant Director of Num MDS Coordinator, the Placehab Service Manager, Service Director, the Die Manager, the Pharmacist Maintenance Director, the Office Manager, the Hou Supervisor, the Staff Dev Coordinator and the Worn Nurse.	the results by the control to the audits r until 100% Int the Medical Nursing, the rsing, the rsing, the rsing, the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the rsing the	9/10/12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445228 07/27/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET LIFE CARE CENTER OF GREENEVILLE GREENEVILLE, TN 37743 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XE) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) How you will identify other residents having F 371 Continued From page 8 F 371 the potential to be affected by the same defiant practice and what corrective action will be taken: This REQUIREMENT is not met as evidenced a) All facility residents have the by: potential to be affected. Based on observation, facility policy review and interview, the facility failed to properly clean and What measures will be put into place or what sanitize by use of the three compartment sink. systematic changes you will make to ensure that the deficient practice does not recur: The findings included: a) All dietary personnel were inserviced on Life Care policy of Observation in the kitchen on July 23, 2012, at Proper Three Compartment Sink 9:38 a.m., revealed Dietary Aide #1 cleaning Wash Sequence and Procedure on three 18/8 pans and the large beater for the 7/23/12. mixer, in the three compartment sink. Continued Dietary manager will monitor and observation at this time revealed the Dietary Aide record weekly for Proper Three washed the pans and the beater, rinsed the pans Compartment Sink Wash Sequence and the beater. Observation revealed the Dietary and Procedure for 4 weeks and Aide then placed the items in the sanitizer part of monthly for 2 months. the sink for 10 seconds and placed the items out to dry. Review of facility policy, Proper Three How the corrective action(s) will be monitored Compartment Sink Wash Sequence and to ensure the deficient practice will not recur: Procedure, revealed "...Immerse washed and Beginning 7/24/12, Dietary Manager rinsed utensils in sanitizer for one minute..." will monitor and record weekly for 4 weeks and monthly for 2 months for Interview and review of the posted sanitizer Proper Three Compartment Sink instructions with the Dietary Manager on July 23, Wash Sequence and Procedure. 2012, at 2:00 p.m., confirmed items cleaned in Results will be turned in the facility's the three compartment sink are to be placed in Executive Director. The Executive the sanitizer for at least one minute prior to taking Director will report findings monthly out of the sanitizer. to the Performance Improvement F 502 483.75(i)(1) ADMINISTRATION Committee. SS=D

of the services.

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness

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	3, 2012, with diagnoral Disease, Diabetes, and Ulcerative Colitical Medical record reviet admission order data "weekly hemoglobin (HCT) every Monday Medical record reviet lab was completed later). Medical record revealed HGB 7.5 (123.0 (42.0 - 52.0). Coreview revealed the May 10, 2012, and consent to the hospital Interview with the Difference and the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administrator's continued to the Administra	dmitted to the facility on May uses including Chronic Kidney Post Hemorrhage Anemia, is with Colectomy. Ew revealed a Physician's red May 3, 2012, to obtain (HGB) and hemocrit (Start May 7, 2012." Ew of the lab reports revealed red on May 9, 2012, (two days ard review of teh lab reports normal 14.0-18.0) with HCT continued medical record Physician was notified on ordered the resident to be for a blood transfusion. Interctor of Nursing (DON) in office on July 26, 2012, at red the Physician's order was a lab was obtained two days			·			